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ABSTRACT

The paper examines barriers faced by educators and administrators in serving young handicapped children in rural areas and suggests approaches to overcoming these barriers. Among problems identified are transportation; funding shortages due to a lower tax base and higher levels of poverty; unemployment, and seasonal employment; staff shortages; isolation leading to high turnover and unavailability of parent support groups; and resistance to change. Federal resources targeted for this population, including the Handicapped Children's Early Education Program and project Headstart, are briefly summarized. Five program models developed to serve one or more problems in service delivery to young handicapped children in rural areas are identified (including the Portage project, the Cooperstown Model, and the Macomb O-3 Rural Project). Program components that have successfully dealt with problems in transportation, funding, staffing, and isolation are noted. (CL)

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# SERVICE DELIVERY TO YOUNG HANDICAPPED CHILDREN IN RURAL AREAS: A REVIEW OF ISSUES AND PRACTICES

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## Introduction

Early intervention for young children with handicaps has been shown to make a positive difference for the children themselves, their families, and communities (Hayden, n.d.). Work with infants with handicapping conditions not only adds to the quality of their lives, but also reduces the total costs of postponing intervention (Breedlove, 1982). Providing services to rural families with young handicapped children may require approaches which are somewhat different from those used in serving urban families.

Rural America is not easy to define. It encompasses a quarter to a third of our population and includes almost every political, social, economic, racial, religious, and geographic category found in the United States.

Rural America has been characterized as being severely disadvantaged; in some cases worse than many inner city areas. On the basis of health, poverty, infant mortality, housing, and level of education, rural areas rank near the bottom (HCEEP Rural Network, 1983).

A region or community may be statistically identified as rural when its inhabitants number less than 150 per square mile or when 60% of the population of the region lives in communities with no more than 5,000 inhabitants. School districts with more than 10,000 students and those within a Standard Metropolitan Statistical Area as determined by the U.S. Census Bureau are not considered rural (Helge, 1981).

Rural families are often monetarily poor, with little or no disposable income, however, they often have land-based resources to provide for their basic needs. By contrast, the urban poor may have no property resources. There is often a more readily identifiable family structure in rural areas, suggesting people who are more capable of coping with problems, which often results in a decrease in their use of outside help (Hutinger, 1981).

Rural areas and communities often have assets such as natural beauty, clean air and water, tranquility, and public safety. They have traditionally contained people with a strong sense of cooperation, self-help, and supportiveness absent in many urban areas. Often several generations of the same family live in close proximity within the community, lending a sense of cohesiveness and support to the nuclear family.

Typically, families with a young handicapped child living in a rural area are long distances from the services they and their children need. Interaction and support from others facing similar challenges is usually unavailable. To obtain medical treatment and educational services long distance travel is often required. In many cases, programs in local areas are unavailable or are very limited because of inadequate funding.

It is the purpose of this paper to examine the barriers faced by educators and administrators in their efforts to serve young handicapped children in rural areas and to analyze several ongoing attempts at overcoming these barriers through the use of formal programs and specific models. The authors' goal is to increase awareness in the problem area and to review some alternatives for service delivery to young handicapped children in rural areas.

## Issues and Problems

### Transportation Issues

Rural school districts, counties, or other designated service areas are usually sparsely populated, with large land areas and long distances between schools and special education services.

Problems of distance are often compounded by difficult terrain, poor roads, and inclement weather. While affecting services in general, these factors have an even greater impact on the services to handicapped children

since special education services are often provided outside the school or center or by itinerant personnel. The result is often discontinuity of service and underserved children. The increased travel time caused by distance and poor roads reduces direct service time to students. Extreme weather conditions may at times totally disrupt services. This applies both when the service provided is by a specialist traveling to the school or home or when the child is transported to the service facility.

Funding Issues

In some instances, rural areas are faced with fewer services for young handicapped children because of funding shortages (Helge, 1981). Sparse population in such areas typically results in lower tax base than most urban areas. Specific factors such as higher levels of poverty, unemployment, and seasonal employment add to the general problems of funding rural areas. Rural communities faced with rapid population growth because of transient industrial development or seasonal population fluctuations present additional funding problems to rural education. In some rural areas funding shortages contribute to the overall difficulty of providing services to the young handicapped child. Whatever the level of funding, the sparse populations of rural areas, the low density of handicapped persons, and the broad range of specific handicapping conditions means the cost per unit of service is greatly increased (Black, 1980).

Staff Issues

Despite sparse populations and scattered students, rural areas have as wide a range of needs for their students as many urban areas. Variance in chronological age, developmental functioning, and handicapping condition can make serving a very small number of students a great challenge.

Insufficient numbers of handicapped students often make funding full-time special education staff difficult to justify. Also, fewer professionals are available from support disciplines such as communication disorders, physical therapy, occupational therapy, and psychology. Special education teachers may have to fulfill some of these responsibilities. Lower numbers of students also make the costs of retaining consultants disproportionately high. The result is that fewer professionals are present and they often serve multiple roles.

Service providers to handicapped children in rural areas are often faced with a scarcity of resources and materials. Typically their salaries are lower than their urban counterparts and their job-related expenses, particularly transportation, are often higher. Their available housing is sometimes substandard.

According to Helge (1981), rural service providers tend to be younger and less experienced than urban professionals performing the same jobs. They perceive themselves as less highly trained than their urban counterparts. Often, they suffer from frustration, boredom, and feelings of social and professional isolation. New recruits to rural intervention may suffer culture shock. Both recruitment and retention are difficult problems for rural special education administrators. In many areas, a constant turnover occurs as special educators leave for higher paying positions in urban areas once they have gained experience.

Isolation Issues

Isolation adds to high turnover. Teachers feel isolated from others in their specialty area and seek urban settings to have closer working relationships with those who have similar interests. They often feel isolated

from opportunities for professional growth. Longer distances to universities, professional libraries, and instructional media centers preclude their utilization by rural-based teaching staff.

Rural areas seldom have local chapters of parent-oriented organizations and support groups are usually unavailable. Information about parental rights and handicapping conditions is less readily available than in urban areas. Because of this, parents may not be meaningfully involved as advocates for their children.

Other Issues

Low-incidence handicapping conditions in rural areas present an even more difficult problem. Such children require extensive intervention from professionals usually available only in urban areas. Alternatives such as homebound instruction, long bus rides to a regional center, or boarding in larger communities raise questions of least restrictive environment and quality of family life.

Language barriers and cultural differences create obstacles for special educators attempting to implement programs for young handicapped children. These differences affect the quality of interaction between parent and service providers. Professionals who speak the minority language are sensitive to the nature of the subculture and who are certified are often difficult to find.

Different economic classes may place less value on educating young handicapped children. Economically deprived parents of handicapped children may have more immediate subsistence concerns than the education of their young children.

Some small rural communities can be resistant to change. There may be hesitancy in the community to adopt changes perceived as being imposed by

external forces, due to the traditionally homogenous nature of rural communities and their long history of self-containment and distrust of outsiders.

In general, many of these factors are present in rural areas and small rural communities today. They have a direct impact on the success of rural special education programs for young children.

## Federal Resources

The following information has been compiled to provide a review of Federal resources addressing the problem of service delivery to young handicapped children in rural areas.

### Handicapped Children's Early Intervention Program

In 1968 Federal legislation was passed establishing a Handicapped Children's Early Education Program (HCEEP). Its purpose was to assist in developing and implementing innovative experimental programs for young handicapped children and their families. HCEEP has evolved into five major components: demonstration projects, technical assistance, outreach, state implementation grants, and childhood research institutes.

Demonstration projects have these components: child identification and assessment, programming for the child, evaluation of child's progress, active family participation, inservice training, coordination with other agencies, project evaluation, and dissemination of project information.

Technical Assistance Development System (TADS) works with demonstration projects and state implementation grants, helping them to meet their objectives and needs. TADS pioneered the development of procedures for systematic delivery of technical assistance. This segment of the program is also active in disseminating information.

The outreach component of HCEEP strives to stimulate the development of high quality services and models for outreach activities. Outreach

programs provide services, but, more important, provide dissemination of and training in model practices.

State implementation grants were designed to help state education agencies expand their ability to develop and expand early intervention services for young handicapped children. The state implementation grants program assists states in developing long-term comprehensive full-service plans for preschool education of the handicapped. It provides administrative resources rather than direct services.

Early childhood research institutes are the most recent component of the Handicapped Children's Early Education Program. These institutes conduct long-term studies to add to knowledge of social, emotional, physical, cognitive, and behavioral aspects of handicapped children. They also study theories and methods of intervention, parent-child interaction, and assessment approaches. Early childhood research institutes strive to find successful methods for intervention with young handicapped children and their families and disseminate this information to all interested parties.

Headstart

The Headstart Program was begun to provide comprehensive services for preschoolers from low-income families. A Congressional mandate requires that not less than 10% of Headstart enrollment opportunities in each state be set aside for handicapped children.

Headstart Program Performance Standards require local programs to develop an education plan that provides procedures for ongoing observation, recording, and evaluation of each child's growth and development for the purpose of planning activities to suit individual needs. Class materials and activities reflect the children's culture and background.

The individual has always been a major thrust of the Headstart Program. Headstart classes are small, making it possible for teachers working with a professional diagnostic team to design and implement programs to meet the special needs and capabilities of each child.

## Project Models

The following is a description of several project models that have been developed to solve one or more problems of service delivery to young handicapped children in rural areas.

### Ski Hi

Ski Hi is a comprehensive model designed for identification, language facilitation, and family support for hearing impaired children. It focuses on home management and serves children from birth to six years. The program is built on these concepts:

1. Language programming and intervention must begin at birth or as soon as possible after.

2. The hearing disorder must be treated immediately by medical treatment and/or amplification. If there is no response to amplification, a total communication program must be implemented.

3. The language program should follow the sequence of natural language development.

4. The program must be in the home. Parents will execute the program and facilitate the language growth of the child.

5. The teacher's role is to teach the parents.

6. The child must be taught to use and develop residual hearing.

7. The language development program is unstructured.

8. Parents and children are provided with emotional and psychological support through the home program.

The three main components of the Ski Hi program are administrative, direct services to families, and supportive services.

The administrative component fosters public awareness, provides screening, and also serves as a referral system. It provides the initial diagnosis for entry into the program.

The direct services component of Ski Hi has three functions: to conduct home visits, to provide intervention, and to support parents. Home intervention can include a home hearing aid program, a home auditory program, and a home language program which may or may not include total communication. An important element of the Ski Hi project is employment and training of interventionists in local communities.

Support offered by Ski Hi includes both parental support, such as child development information, psychological and emotional support, and support services. These services might include audiological services, hearing aid services, and materials and equipment for parents.

The Portage Project

The Portage Project of Portage, Wisconsin, is a structured, data-based, individualized program. It has been replicated extensively and has received national recognition. It uses a precision teaching model and focuses on effective parent involvement, with the parent as the child's primary teacher.

Portage serves multicategorical handicapped children from birth to six years of age. A developmental curriculum and checklist of skills (Portage Guide to Early Education, Bluma et al., 1976) is used for instructional planning. Parents are provided with written activity charts, modeling, discussion, and feedback to help them effectively teach their child.

Components of the model:

1. Parents are the child's primary teacher.

2. Ongoing assessment procedures are used to assure appropriate curriculum planning.

3. Individualized curriculum planning including written activity charts that show: what to teach, how to record child's progress, materials needed, directions on how to teach the activity, correction procedures, reinforcement to be used, and time and place to teach if appropriate.

4. Home teaching process: Teacher takes post-baseline on previous week's activity, teacher models new activity for parent and takes baseline, parent models new activity for teacher, parent and teacher review activities, parent works on activities during the week.

5. Maintenance of a behavioral log that shows behaviors the child has learned, in what developmental area, when the activity was prescribed, when the child accomplished it, and what activities the child is currently working on.

6. Weekly staff inservice meetings to increase teacher skills.

7. Ongoing project evaluation.

Cooperstown

The Cooperstown Model was developed by Headstart in Cooperstown, New York, to serve rural preschool noncategorical handicapped children. It consists of three components: videotape recording procedure, mobile resource center, and child service specialist.

A videotape recording procedure is used as an observation and evaluation tool. In situations where experts cannot meet with a child, the videotape provides a behavior sample. It also provides a permanent record against

which the child's progress can be assessed. The videotape can be used to introduce a child to a new agency, in such instances as a child moving from Headstart to public school or to another community.

The Cooperstown Mobile Resource Center is a van fitted as a classroom that takes Headstart to remote areas. It provides a mainstream experience for young preschool children in rural areas. The Mobile Resource Center staff provide a half-day program using the mobile center as a classroom and spend afternoons working with parents and children in their homes. The mobile center includes a parent-child take-home library and a toy lending library. The Mobile Resource Center offers a full range of services, using multidisciplinary diagnostic teams and coordination with other agencies.

The third component of the Cooperstown Model is a child services specialist. This staff member works directly with the child and the family. A child services specialist intervenes for the family whenever necessary between parents and the Headstart staff and other agency staff or medical personnel. They also help arrange services, therapy, evaluations, and help with transportation if needed.

Macomb

The Macomb 0-3 Rural Project in rural Illinois is a project that is curriculum-based and has an ecological perspective. Because the exact nature of handicapping conditions is often difficult to diagnose in the first three years of life, a noncategorical approach is used. High-risk infants are also served by this program. Public school districts in rural areas provide classrooms and transportation for preschool handicapped children.

The Macomb Project stresses that parental involvement, cooperation, and enthusiasm are necessary for success. It consists of three components:

home visits, sharing centers, and recreational water activities. Child development specialists are trained to serve a variety of functions. A room on wheels is available for use as a home site classroom or training center when the home is inappropriate for home visits.

Home visits occur at various intervals ranging from biweekly to monthly, depending on the particular child's needs. The visits are conducted by the child development specialist and the parent or primary caretaker is included in each visit.

The sharing center component functions as a transition between home and center-based programs. Parents, siblings, and friends participate every two weeks in sessions where parents interact with children and topics of interest are studied.

The water activity component involves moms and handicapped children joining a Mom & Tots swim class along with regular class participants. This provides a mainstream experience for the children and a recreation activity for the mother and her child to enjoy together.

The Macomb Project provides an educational remedial program for optimal development of handicapped children in rural areas. It helps parents in rural areas acquire the skills and knowledge they need to become more effective in coping with their children and teaching them new skills.

The Family, Infant, and Toddler Project: Early Intervention for Rural Families

The Family, Infant, and Toddler Project (FIT) takes an ecological perspective. Its major goal is to strengthen linkages between systems affecting the target child. FIT developers regard families and communities as important resources for young handicapped children.

The Family, Infant, and Toddler Project has these major goals:

1. To develop a demonstration service program in rural Tennessee.

2. To train professionals.

3. To expand services to young mentally retarded children and their families in rural areas.

The project serves mentally retarded children from birth to four years of age.

The components of the program include weekly education clinics where parents are trained to enhance their child's development. These clinics usually involve small groups of five handicapped children and their families. The sessions include individual parent and child training, group parent training and discussion, and a children's activity group. Parents are exposed to general information regarding child development, child rearing, community resources, and group support. During the children's group, professionals observe the individual children's behavior in a group setting.

Extended family clinics are another component of FIT. These clinics are held in the evening every six to eight weeks. They are designed to provide information about mental retardation and to develop constructive ideas, values, and attitudes toward mental retardation. Information is provided during the clinics on ways to be helpful to parents of retarded children and how to cope with the emotional crisis of having a handicapped child.

A third component of the Family, Infant, and Toddler Project is local allied professional training program. This training program is aimed at rural professionals. With further training there is the potential to increase and expand the services they provide to the target population.

## Practices in Relation to Issues and Problems

While the problems of service delivery to young handicapped children in rural areas are numerous and varied, and solutions difficult, the implementation of new ideas and techniques may bring about many beneficial changes. Some of the problems that have been addressed by different programs include the following.

### Transportation Problems

Problems related to transportation are being solved by increased use of home-based models. When a home visitor comes to the child, the problem of long bus rides for the child is avoided. These programs require no classroom space and the home visitor can bring resource materials to the parents. A home-based program reinforces the "parent as a teacher" and utilizes the child's natural learning environment.

In some programs, the solution to the transportation problem has been to take the classroom to the child. The learning center on wheels or mobile classroom concept is one that some remote areas are using to provide services to young children with handicaps. A bus or motor home functions as a complete classroom or sharing center when it is driven to the community where services are needed. Transportation to the mobile classroom within the community can be provided by parents, carpools, or, in some cases, the mobile classroom picks up each child at his home before class begins.

Long distances create problems for itinerant professionals traveling to serve children in rural areas. In some areas, consultants for low-incidence handicaps and other specific problems may be unavailable. In some of these cases, videotape can serve a variety of functions. It can provide information on child development and child management techniques and

demonstrate teaching procedures to parents or community-based staff (Cooperstown, 1976). Videotapes can also be used as an assessment technique (Cook, 1977). For example, a tape of a child's behavior can be sent to an expert located in an urban area in instances where that person is unable to visit the child. A videotape can likewise serve as a permanent record of a child's level of functioning, following him through his school career, with periodic additions, serving as a standard by which to evaluate progress. Videotape is often a cost effective technique when compared with the expense of transporting a rural-based child to a diagnostic center located in a city a great distance away.

Housing and transportation for programs serving preschool handicapped children are two problems that are being solved in some rural areas by placing preschool special education programs in public school buildings and using public school transportation. The school districts provide a classroom in a central location and bus handicapped preschoolers on the regular scheduled bus runs, bringing them back from a half-day program with the kindergarten students. This seems to be a cost effective solution, since in many areas neither buildings nor buses are full and the system is already operational in the rural community. There may be resistance to this solution, however, from public school districts who have not traditionally provided education for preschoolers and opposition from other service providers who have established programs to serve handicapped preschoolers.

However, according to Thomas (1982), the public school is the agency most equipped to deliver comprehensive educational services to large numbers of children. To build a comprehensive and cohesive alternative system would mean duplication of effort. Current fragmentation and unevenness of service

delivery systems found in most communities argue for change. A paramount need exists for a central authority for organizing and implementing early intervention programs. One choice is the public schools.

Funding Problems

Funding shortfalls may be made up in a variety of ways. Solutions include augmentation from organizations such as community mental health, developmental disabilities council, mental retardation boards, special education department, and the Federal Assistance Department.

Local service providers in some areas have obtained funds from charitable organizations such as United Way, Easter Seal Society, and the Association for Aid to Crippled Children.

Many programs strive for cost effective delivery and efficient implementation. Others obtain funds from local industries and influential citizens. Many also rely on donated space, services, materials, or transportation.

In some rural areas professionals have obtained grants for funds to provide early childhood education for handicapped children.

Staffing Problems

Problems related to staff are being resolved in a variety of ways. Paraprofessionals available in rural communities are being utilized in providing services to young handicapped children. Parents are assisted by these paraprofessionals in helping their children's skills. The paraprofessionals implement programs that have been developed by certified staff. These same staffpersons also train and supervise the paraprofessionals. This approach can ease the shortage of available qualified special educators.

Mobile assessment teams have been used for areas that do not have a wide range of professionals available to assess their handicapped children.

Mobile assessment teams that cover large areas allow cost effective professional diagnostic assessment in rural areas.

Networking or linking is a concept where community agencies band together into a network for functions such as child find and cross referral, and to utilize existing services rather than duplicating programs. Some agencies use existing groups in the community to provide group experience for handicapped preschoolers. They then act in a consulting role to groups such as Title I, Headstart, special education, day care centers, or day care homes.

In sparsely populated areas the development of special education administrative units larger than a school district or service area may allow for a broader range of administrators, therapists, diagnostic staff, and professionals.

Better staff training and more appropriate staff placement can help alleviate staff recruitment and turn-over problems. Retraining existing local educational personnel or paraprofessionals eliminates problems of culture shock when staff move from urban areas to rural communities. Another solution may be more "field-centered" teacher training programs with a focus on rural schools. Adjustment problems are lessened when special educators have spent time living and working in rural areas during their training.

Focusing on advantages of rural living can attract educators who will appreciate the natural beauty, quiet, and sense of community spirit rural communities usually offer.

General Isolation

Telecommunications is being used in many areas as a service delivery tool for young handicapped children in remote and rural areas. Specific

applications include contact with homebound children, using closed circuit television, special frequency radio, and telephones. Some areas have a toll-free line that parents may use to contact master teachers for specific information or to obtain support services.

Projects using minicomputer-based control systems to provide home instruction to severely handicapped preschoolers have been developed. These systems were designed to work on such skills as increasing strength or rate of motor response or visual discrimination (Tawney, 1979).

Various procedures have been used in areas that are not just rural but extremely remote, in particular Alaska. In some cases, programs have resorted to flying services, despite the expsnse. In areas that are quite sparsely settled and have inadequate roads, this approach may be the only solution. Flying professionals visit communities on a rotating basis to provide education for young handicapped students.

Regional boarding facilities provide another solution to remote rural areas. They can be used on a short-term basis for diagnosis, decisions on remedial methods, and as teacher training units.

Parental Isolation

Parents in rural settings are often without support groups and services that are available in areas with larger population bases. They suffer from isolation, lack of educational programs for their children, and lack of information and respite care. Staff social workers are sometimes used to bridge these gaps and provide crisis intervention, educational/social activities outside school hours, homebound instruction, individualized teaching or training sessions, and escort and transportation services. They also serve as links between home, school agencies, medical personnel, and other service

organizations. Parents sometimes need a professional to help them sort out conflicting opinions and various options offered by service providers and a social worker can fulfill this role.

Parents of young handicapped children can serve as an excellent support group for other families coming to terms with their role as parents of a handicapped child. Parent groups or committees who serve as volunteers to help others facing similar problems can be good sources of support, information, and even cooperative respite care. These groups may take many forms, including large regularly scheduled meetings to share common concerns, informal small group meetings in parents' homes, or one-on-one help from a parent who has experienced similar situations. In some areas where groups have not formed a parent newsletter shares information, concerns, and sources of help.

In taking an ecological perspective, the child and his social system are viewed as interdependent targets for intervention. Families and communities are important resources for a handicapped child, especially in a rural area where other support may be unavailable. Strengthening bonds between a handicapped child, his immediate family, his extended family, and community can help alleviate the isolation of the child and his parents (FIT, 1978). Information about the handicapping condition and understanding of general techniques for coping help extended families and the community as a whole to provide needed support. Treating the family as a whole and realizing the handicapped child has an impact on all members has resulted in the inclusion of siblings as well as parents in some groups, and the addition of extended family clinics to parent groups.

## Conclusion

An ideal approach would be to offer a continuum of services, ranging from programs delivered in homes to programs delivered in centers and including any other support services needed by families. Children, families, and communities are different, as are handicapping conditions, and it is unrealistic to provide one model of service for all. Families have different needs, different demands on their time, and different resources available to them. The most thoughtful approach would be to match the needs of the child and family to the most appropriate program (Thomas, 1982).

Rural America has many strengths that can be enhanced to help solve problems in service delivery to young handicapped children. Rural communities have a strong sense of self-sufficiency, community, cooperation, and supportiveness. If agencies and special educators can channel these strengths towards providing quality services to their young handicapped members while providing funding, expertise, innovative solutions, and support, rural America will be on its way to providing needed educational opportunities to young handicapped children and their families.

References

Baldwin, J. Part of a team: The delivery of social services within a preschool special education setting. The Ochlocknee Project, S.W. Georgia Program for Exceptional Children, 1976.

Becklund, J., & Gaasholt, M.P. Reaching Beyond the City: Special Education in Non-Urban Settings. Program Development Assistance System, University of Washington.

Black, T., & others. Serving young handicapped children in rural America. Proceedings of the HCEEP Rural Workshop. Chapel Hill, North Carolina: TADS, 1980.

Breedlove, C., & Schweinhart, L. The cost effectiveness of high quality early childhood programs. Southern Governors' Conference Report, 1982.

Clark, T., & Watkins, S. Ski Hi Project. U.S. Office of Education, Bureau of Education for the Handicapped, 1978.

Cook, P., & Authier, G. Assessment by Developmental Profile and by Coding of Videotapes. Presented at the Annual International Convention, The Council for Exceptional Children, April, 1977.

Ellis, N., & Cross, L. Planning Programs for Early Education of the Handicapped. Walker & Company, 1977.

Figet, P., & others. Management Manual for Cooperative Home-Based Preschool Program. Early Childhood Program for the Handicapped. Presented at the Annual International Convention of the Council for Exceptional Children, April, 1980.

Hayden, A., & McGinness, G. Basis for Early Intervention. Manus[illegible]n-dated).

Helge, D. Problems in implementing comprehensive special education programming in rural areas. Exceptional Children, April, 1981, 47, 514-520.

Helge, D. Rural Preservice Preparation: A Planning Framework: Current and Future Activities. Manuscript, October, 1982.

Hutinger, P. The Macomb 0-3 Regional Project: Service delivery model for children birth to 3 in rural areas. Monograph No. 2 MR/DD Services in Rural America - It Is Time, December, 1979, Vol. 1.

Hutinger, P. Reaching rural handicapped children: The transportation situation in rural service delivery. Making it work in rural communities. Monograph, June, 1981.

Hutinger, P. What's rural? An overview of successful strategies used by rural programs for young handicapped children. Making it work in rural communities. Monograph, June, 1981.

Lehnhoff, N., & others. Early Childhood Education: Promising Practices in Rural Areas. Portland, Oregon: National Federation for Improvement of Rural Education, Northwest Region, Education Lab, February, 1976.

Lynch, E., & Simms, B. Mainstreaming Preschoolers: Children with Mental Retardation. U.S. Department of Health and Welfare (undated).

Parks, A.L. Teaching in Rural Areas: Is It Really That Different? Manuscript, September, 1983.

Richards, M.J. Early Childhood Education At Home Project. Final Report, Curriculum Improvement Center, Martinsburg, West Virginia, January, 1975.

Schalock, R. The Family, Infant, and Toddler Project: Early intervention for rural families. Monograph No. 2 MR/DD Services in Rural America - It Is Time, December, 1979, Vol. 1.

Tawney, J.W., & others. Using telecommunications technology to instruct rural severely handicapped children. Exceptional Children, October, 1979, 46(2), 118-125.

Thomas, M. Current concerns of early childhood educators: A conversation with Diane Bricker. Education and Training of the Mentally Retarded, April, 1982.

Travers, J., & Light, R. (Eds.). Learning from Experience: Evaluating Early Childhood Demonstration Programs. Panel on Outcome Measurement in Early Childhood Demonstration Program, Committee on Child Development Research and Public Policy, Washington, D.C., 1982.

Wachtel, W.J., & others. Self Assessment of Knowledge and Training Needs for Personnel Serving Preschool Aged Handicapped Children: A Rural-Urban Comparison. Paper presented at the Annual Rural Research Conference, February, 1983.

Wilcox, R.K., & Garlich, R.A. Delivery of Services to Rural Preschool Handicapped Children: Final Performance Report. Children's Therapy Center of Pettis County, Inc., Sedalia, Missouri, June, 1979.

The Cooperstown Model: A Project to Serve Preschool Children with Special Needs. Opportunities for Otsego, Inc. Cooperstown, New York: Headstart in Otsego County, 1976.

Handicapped Children's Early Education Program, 1980-81 Overview and Directory. Lambour, G., Project Officer. Washington, D.C.: HCEEP, U.S. Department of Education.

Project Family Link I Year III Final Report, July 1979 through June 1980, Texas University, Lubbock, Texas. Washington, D.C.: Bureau of Education for the Handicapped.

Project Home Base. Yakima, Washington: Yakima School District.

Project Telepac. Logan, Utah: Utah State University.